

R: 8/21/02
MDE/OSE/EIS

UNIVERSITY/COLLEGE PROGRAM VERIFICATION

To ISD: _____, Supt. From: _____
Address: _____ Univ./Coll. Code # _____
_____ Office of Special Education and
_____ Early Intervention Services
Candidate Name: _____
SS#: _____

REQUESTED BY: _____
SCHOOL DIST.: _____
ADDRESS: _____

This candidate is enrolled in the following training program:

<input type="checkbox"/> Emotional Impairment	<input type="checkbox"/> Physical Impairment & Other Health Impairment
<input type="checkbox"/> Learning Disabilities	<input type="checkbox"/> Physical Education for the Handicapped
<input type="checkbox"/> Cognitive Impairment	<input type="checkbox"/> Visual Impairment
<input type="checkbox"/> Autism	<input type="checkbox"/> Director
<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Supervisor
<input type="checkbox"/> Early Childhood Special Education	

This request applies to the school year 20__ - 20__.

For continuing temporary approval only:

I verify that the candidate has completed ____ semester hours toward full approval or endorsement between September 1 and August 31 of the previous school year.

If this candidate did not complete the required 6 semester hours for continuing approval, was additional coursework available? ☐ Yes ☐ No

Evaluator: _____ Date: _____

RSB:alb